CHAPTER 72

NJ CARE … SPECIAL MEDICAID PROGRAMS MANUAL

TABLE OF CONTENTS

SUBCHAPTER 1. INTRODUCTION

10:72-1.1 Purpose

(a) This chapter contains the criteria for Medicaid eligibility for certain pregnant women and infants not eligible under the provisions of N.J.A.C. 10:81 and 82, as well as, certain aged, blind, and disabled persons not eligible under the provisions of N.J.A.C. 10:71.

1. Because the eligibility criteria established by the rules contained within this chapter are more liberal than those applicable under AFDC-related Medicaid and SSI-related Medicaid, pregnant women, infants, and aged, blind or disabled individuals losing Medicaid eligibility because of financial reasons should be evaluated under the provisions of this chapter for the possibility of continuing Medicaid eligibility.

2. Except for children between the ages of one and 19, persons financially ineligible for Medicaid under the provisions of N.J.A.C. 10:71, 10:81 and 10:82 and who are income ineligible for Medicaid under the provisions of this chapter shall be evaluated for eligibility as Medically Needy under the provisions of N.J.A.C. 10:70.

i. Persons determined eligible for the Medically Needy Program may be also determined eligible as Specified Low-Income Medicare Beneficiaries.

3. Infants not eligible under the provisions of N.J.A.C. 10:71, 10:72, 10:81 or 10:82 should be evaluated for NJ KidCare under the provisions of N.J.A.C. 10:79.

(b) Medicaid eligibility under the provisions of this chapter is limited to:

1. Pregnant women; and

2. Infants under the age of one.

3. Aged, blind, and disabled individuals (as defined by Title XIX of the Social Security Act), who otherwise meet the requirements specified in this chapter. For purposes of this chapter, an aged individual is a person who is 65 years of age or older.

4. Aged, blind, and disabled individuals (as defined in (b)3 above) who qualify as Specified Low-Income Medicare Beneficiaries.

i. Specified low-income Medicare beneficiaries must be residents of the State, must be receiving Medicare benefits, Parts A and B, and must meet the income and resource requirements specified in N.J.A.C. 10:72-4.1(b) and 4.5(b).

ii. The enrollment and outreach process for specified low-income Medicare beneficiaries is administered by the Department of Health and Senior Services, through the Office of Pharmaceutical Assistance to the Aged and Disabled (PAAD), using the standard PAAD application form.

iii. Persons determined eligible as specified low-income Medicare beneficiaries are entitled to payment of Medicare Part B Premiums only, beginning in the month of application and up to three prior months, but no earlier than January 1, 1993.

iv. The Division of Medical Assistance and Health Services shall promptly notify any applicant for, or beneficiary of, the Specified Low-Income Medicare Beneficiary benefit, in writing, of any agency decision affecting the application disposition or the receipt of the benefit. When a decision relates to any adverse action which may entitle an

individual to a fair hearing, the action may not be implemented until at least 10 days after the mailing of the notice. Such notices shall conform with provisions at N.J.A.C. 10:72-5.1(b).

(c) Retroactive Medicaid eligibility is available beginning with the third month prior to the month of application for Medicaid for any month during which the applicant meets all eligibility criteria and during which the applicant has unpaid medical expenses for covered services. In order to qualify for retroactive coverage, an individual need not be determined eligible at the time of application for Medicaid benefits. Application for retroactive Medicaid coverage may be made on behalf of a deceased person so long as the person was alive during a portion of the three-month period immediately prior to the month of application and he or she has unpaid medical expenses for Medicaid covered services.

1. Retroactive Medicaid coverage is not available under the provisions of this chapter for an infant for any period prior to the effective date of program coverage for the age of the child. Retroactive eligibility is not available to pregnant women and infants up to the age of one whose family income exceeds 133 percent of the Federal poverty guideline for any period prior to July 1, 1991.

10:72-1.2 Purpose

(a) The purpose of the rules contained within this chapter is to:

1. Set forth eligibility criteria for the Medicaid program; and
2. Specify the rights and responsibilities of program applicants and eligible persons.

(b) Circumstances which are neither specifically nor generally addressed in these regulations shall be referred to designated staff of the Division of Medical Assistance and Health Services for resolution.

(c) The director of the county welfare agency shall assign copies of this chapter to administrative staff, all staff responsible for the determination of Medicaid eligibility for pregnant women, infants, aged, blind and disabled individuals and to social service staff as appropriate and shall ensure that each staff member is thoroughly familiar with its requirements in order to apply the policy and procedures consistently.

(d) The Division of Medical Assistance and Health Services will issue revisions to this chapter as they are promulgated in accordance with New Jersey Administrative Procedures Act, N.J.S.A. 52:14B-1 et seq.

i. At least one administrative copy of all obsolete pages of this chapter must be maintained by the county welfare agency.

(e) This chapter is a public document. All copies in use must be updated accurately as revisions are issued. The chapter is available as follows:

1. Copies are available in the State offices of the Division of Medical Assistance and Health Services and in each county welfare office for examination and review during regular office hours.

2. Specific policy material necessary for an applicant or recipient or his or her representative to determine whether a fair hearing is to be requested or to prepare for a fair hearing shall be provided to such persons without charge.

3. All public and university libraries which have agreed to maintain the chapter up-to-date will have a copy available under their regulations.

4. Welfare, social service, and other nonprofit organizations will be furnished with a copy of this chapter at no cost upon an official written request on agency letterhead to the Division of Medical Assistance and Health Services.

5. A current up-to-date copy of this chapter is available from the Division of Medical Assistance and Health Services at the cost of printing and mailing to anyone who requests it in writing.

10:72-1.3 Administrative organization

Financial eligibility for the Medicaid program is administered by the county welfare agencies under the supervision of the Division of Medical Assistance and Health Services.

10:72-1.4 Principles of administration

(a) The following principles of administration apply in the Medicaid program.

1. Opportunity to make application: Any individual who believes he or she is eligible shall be afforded an opportunity to make application (or reapplication) for the Medicaid program without delay.

2. Primary source of information: Program applicants or eligible persons are the primary source of information concerning program eligibility. The county welfare agency shall, when necessary, in the process of determining eligibility, use secondary sources of information with the knowledge and consent of the applicant or eligible person.

3. Adherence to law and administrative policy: There shall be strict adherence to law and complete conformity with rules and administrative policy. Requirements other than those established by law or rule shall not be imposed as a condition of receiving assistance under the Medicaid program.

10:72-1.5 Confidentiality of information

(a) No member, officer, or employee of the county welfare agency shall produce or disclose any confidential information to any person except as authorized below.

1. Information considered confidential includes, but is not limited to, the following:

i. Names and addresses;

ii. Medical services provided;

iii. Social and economic conditions and circumstances;

iv. County welfare agency evaluation of personal information; and

v. Medical data, including diagnosis and past history of disease or disability.

2. The county welfare agency may disclose information concerning an applicant or eligible person to persons and agencies directly related to the administration of the Medicaid program. Persons and agencies directly related to program administration are those who are properly authorized to be involved in the following:

i. The establishment of eligibility;

ii. The determination of the amount and scope of medical assistance;

iii. The provision of services for beneficiaries; and

iv. The conduct or assisting in the conduct of an investigation, prosecution, or civil or criminal proceeding related to the Medicaid program.

3. The county welfare agency may release information whenever the applicant or eligible person waives confidentiality, but only to the extent authorized by the waiver.

4. If a court issues a subpoena for a case record or any other confidential information or for any agency representative to testify concerning an applicant or eligible person, the county welfare agency shall make a statement substantially as follows:

i. "Under provisions of the Social Security Act, information concerning applicants and beneficiaries of medical assistance must be restricted to persons directly connected to the administration of such assistance. Officials of the Federal government have advised that this includes a requirement of nondisclosure of such information in response to a subpoena. If a disclosure is made of this information, either by personal testimony or by the protection of records, this is considered nonconformance with Federal requirements and may subject the State to loss of Federal financial participation in the medical assistance program."

5. In no instance is it intended that any officer or employee of the county welfare agency place him or herself in contempt of court through the refusal to follow orders of the court. In any instance of a subpoena for case record information or for agency testimony, a complete report of the disposition of the court's request shall be entered into the case record.

6. Pertinent information and records may be released in conjunction with an administrative hearing conducted by the Office of Administrative Law regarding action or inaction of the county welfare agency affecting an applicant's or eligible person's eligibility or entitlement under the Medicaid program.

10:72-1.6 Materials distributed to Medicaid applicants or eligible persons

(a) All materials distributed to program applicants or eligible persons must:

1. Directly relate to the administration of the Medicaid program;

2. Have no political implications;

3. Contain names only of individuals directly connected with the administration of the Medicaid program; and

4. Identify those individuals only in their capacity with the State or the county welfare agency.

(b) The county welfare agency shall not distribute materials such as "holiday" greetings, general public announcements, voting information, or alien registration notices.

(c) The county welfare agency may distribute materials directly related to the health and welfare of program applicants and eligible persons, such as announcements of free medical examinations, availability of surplus food, and consumer protection information.

10:72-1.7 Nondiscrimination

(a) Title VI of the Federal Civil Rights Act of 1964 (P.L. 88-352) and section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 70b) and the Americans with Disabilities Act, P.L. 101-336, codified as 42 U.S.C. § § 12101 et seq., prohibits discrimination on the ground of race, color, national origin, or handicap in the administration of any program for which Federal funds are received. Strict compliance with the provisions of these Acts and any regulations based thereon is required as a condition to receive Federal funds for the assistance programs administered by the county welfare agencies. These principles apply to the Medicaid program in New Jersey.

1. The county welfare agency shall inform all staff members of their obligations in regard to the Civil Rights Act of 1964 and section 504 of the Rehabilitation Act of 1973.

2. All persons seeking medical assistance shall be informed of Title VI of the Civil Rights Act of 1964 and section 504 of the Rehabilitation Act of 1973.

3. All persons seeking or receiving medical assistance shall be afforded an opportunity to file a complaint alleging discrimination on the ground of race, color, national origin, or handicap. Such complaints may be filed directly with the Regional Manager, U.S. Department of Health and Human Services, Office of Civil Rights, Federal Plaza, New York, New York 10007, or with the Director, Division of Medical Assistance and Health Services, PO Box 712, Trenton, New Jersey 08625-0712.

4. In any instance in which a complaint of alleged discrimination is filed with a State or county agency, the complaint shall be forwarded immediately to the Director, Division of Medical Assistance and Health Services. The Director, upon receipt of any such complaint, will take any such action he or she deems appropriate to the situation. This action may include, but is not limited to, the securing of reports from whatever sources have knowledge pertinent to the situation and referral to the Division of Civil Rights of the New Jersey Department of Law and Public Safety, for investigation, evaluation, and recommendation by that agency.

5. The county welfare agency shall afford full cooperation in the investigation of complaints of discrimination as may be requested by the Federal Department of Health and Human Services, the State Division of Medical Assistance and Health Services, or the State Division of Civil Rights.

10:72-1.8 Assignment of medical support rights

(a) Any person who applies for Medicaid, by virtue of the application for benefits, is deemed to have assigned to the Commissioner of the Department of Human Services

any rights to support for the purpose of medical care as determined by a court or administrative order and any rights to payment for care from any third party. Program applicants and beneficiaries are required to cooperate in the identification of and the obtainment of any such rights.

1. The county welfare agency shall advise program applicants and beneficiaries of the terms of the assignment and the consequences thereto.

END OF SUBCHAPTER 1

SUBCHAPTER 2. CASE PROCESSING

10:72-2.1 Application

(a) Application for Medicaid benefits for pregnant women and infants shall be accomplished by the completion and signing of Form FD-335 for pregnant women and infants as well as any addenda to that form as prescribed by the Division of Medical Assistance and Health Services. Application for Medicaid benefits for aged, blind, or disabled individuals shall be accomplished by the completion and signing of Form PA-1G as well as any addenda to that form as prescribed by the Division of Medical Assistance and Health Services.

1. The application for the program shall be executed by:

i. The pregnant woman (regardless of age);

ii. The parent, guardian, or caretaker relative of an infant or a blind or disabled child for whom Medicaid is sought; or

iii. The aged, blind or disabled individual.

2. For cases in which, because of confinement, illness, incapacity, disability, or lack of competence of a person specified in (a)1 above, the application may be executed on behalf of such person by:

i. A relative by blood or marriage;

ii. A staff member of a public or private welfare or social service agency of which the person seeking assistance is a client and who has been designated by the agency to so act;

iii. An attorney or physician of the person seeking Medicaid benefits; or

iv. A staff member of an institution or facility in which the individual is receiving care and who has been designated by the institution or facility to so act.

3. A legal guardian shall be recognized as an authorized agent to execute an application on behalf of any individual.

(b) The county welfare agency, under policies and procedures established by the Division of Medical Assistance and Health Services, has the direct responsibility in the application process to:

1. Inform applicants of the purpose of and the eligibility requirements for the Medicaid program, including their rights to a fair hearing;

2. Receive applications and review them for completeness, consistency, and reasonableness;

3. Assist program applicants in exploring their eligibility for program benefits;

4. Make known to program applicants the appropriate resources and services both within the agency and in the community; and

5. Assure the prompt and accurate submission of eligibility data to the Medicaid Eligibility File for eligible persons and prompt notification to ineligible persons of the reason for their ineligibility.

(c) As part of the application process, an applicant for Medicaid has the responsibility to:

1. Complete, with the assistance of the county welfare agency as required, any forms required as part of the application process;

2. Assist the county welfare agency in securing evidence that verifies his or her statements regarding eligibility;

3. Provide medical confirmation of pregnancy when Medicaid benefits are sought on that basis; and

4. Submit to necessary medical tests and examinations to determine disability or blindness and provide the county welfare agency with evidence relating to that determination.

(d) For any application for Medicaid benefits under the provisions of this chapter, the county welfare agency must accomplish disposition of the application as soon as all factors of eligibility are met and verified but not later than 30 days from the date of application (or from the date of the inquiry form PA-1C, if applicable) for pregnant women, children, and aged individuals. For disabled and blind individuals, the standard for application disposition is 60 days. Exceptions to the timeliness standard appear in (d)2 below.

1. "Disposition of the application" means the official determination by the county welfare agency of eligibility or ineligibility of the applicant(s) for Medicaid.

2. Disposition of the application may exceed the applicable processing standard when substantially reliable evidence of eligibility or entitlement for benefits is lacking at the end of the processing period. In such circumstances, the application may be continued in pending status. The county welfare agency shall fully document in the case record the circumstances of the delayed application processing. The processing standard may be exceeded for any of the following:

i. Circumstances wholly within the control of the applicant;

ii. A determination by the county welfare agency, when evidence of eligibility or entitlement is incomplete or inconclusive, to afford the applicant additional time to provide evidence of eligibility before final action on the application;

iii. An administrative or other emergency that could not reasonably have been avoided;

iv. Circumstances wholly beyond the control of both the applicant and the county welfare agency.

3. When disposition of the application is delayed beyond the processing standard, the county welfare agency shall provide the applicant written notification prior to the expiration of the processing period setting forth the specific reasons for the delay.

4. Each county welfare agency director shall establish appropriate operational controls to expedite the processing of applications and to assure maximum compliance with the processing standard.

i. The county welfare agency shall maintain control records which identify all pending

applications which have exceeded the processing standard and the reason therefor. The record shall be adequate to make possible the preparation of reports of such information as may be requested by the Division of Medical Assistance and Health Services.

(e) The following actions on an application qualify as disposition of an application for purposes of the processing standard:

1. Approved: The applicant has been determined eligible for Medicaid;
2. Denied: The applicant has been determined ineligible for Medicaid;
3. Dismissed: A decision by the county welfare agency that the application process need not be completed because:

i. The applicant has died (the application process must be completed if there are unpaid medical bills for covered services in the retroactive coverage period or subsequent to program application);

ii. The applicant cannot be located;

iii. The application was registered in error;

iv. The applicant has moved out of the State during the application process and there are no unpaid bills for the time period beginning with the retroactive eligibility period up to the date of relocation.

4. Withdrawn: The applicant requests that eligibility for the Medicaid program be no longer considered.

10:72-2.2 Interview

The county welfare agency is required to conduct a personal face-to-face interview with the program applicant or the authorized agents as part of the process of determining program eligibility.

10:72-2.3 Verification requirements

(a) The county welfare agency is required to verify all factors related to eligibility for the Medicaid program. Factors subject to verification include:

1. Pregnancy: For women seeking benefits under the provisions of this chapter, pregnancy must be medically verified. The medical verification must include the estimated dates of conception and delivery.
2. Disability and blindness: For individuals seeking Medicaid benefits because of disability or blindness, the condition must be established in accordance with the definitions, verification requirements, and processes set forth at N.J.A.C. 10:71-3.10 through 3.13.
3. Birth date: The birth date of any person for whom benefits are sought must be verified.
4. Alien status: The status of any alien seeking benefits must be verified to establish entitlement for Medicaid benefits.
5. Citizenship: When an applicant's or beneficiary's statements of U.S. citizenship are

questionable, citizenship must be verified.

6. Household composition: The county welfare agency must verify the household composition in order to ascertain which persons will be included in the determination of eligibility for Medicaid benefits.

7. Social Security number: The Social Security number of any person seeking Medicaid benefits must be verified.

8. The county welfare agency must verify all sources of income of any person whose income must be counted in the determination of program eligibility. While resources are not a factor of eligibility for benefits for pregnant women and children under this chapter, resources must be identified and verified to determine if income is derived from the resources. For the aged, blind, and disabled, resources must be verified.

(b) The county welfare agency shall use documentary evidence as the primary source of verification. Documentary evidence is written confirmation of the family's circumstances. It is the responsibility of the applicant to obtain or to assist the county welfare agency in obtaining any required documentation.

(c) In circumstances in which the documentary evidence is questionable or is not available, the county welfare agency may use collateral contact to confirm the family's circumstances. A collateral contact is a verbal confirmation of a family's circumstances by a person outside the family. In order to be acceptable as verification, a collateral contact must be in a position to provide accurate information about the family and the circumstance in question.

(d) Subsequent to the initial application, verification is required for only those factors of eligibility which are subject to change or for those factors for which the original verification has become questionable.

(e) In the absence of credible verification of all eligibility factors, eligibility for the Medicaid program may not be established.

10:72-2.4 Case transfer

(a) When individuals move permanently to another county within the State, responsibility for the case shall be transferred in accordance with the provisions of this section. The case transfer shall be accomplished in a manner so as not to adversely affect the rights of any individual to program entitlement.

1. A temporary visit out-of-county shall not be considered to be a change of county residence until the visit has continued for longer than three calendar months.

(b) The county of origin shall initiate and the receiving county shall, on request, immediately undertake an investigation of the circumstances surrounding the move. If the move is permanent, each county shall execute its respective responsibilities in

accordance with (c) and (d) below.

(c) Applicant cases: For persons who move from the county in which application for Medicaid is made prior to the determination of eligibility or ineligibility:

1. The county in which the application was made has the responsibility to:

i. Complete the eligibility determination process;

ii. If determined eligible for the Medicaid program, accrete the eligible person(s) to the Medicaid Eligibility File with the correct effective date of Medicaid eligibility and the new address in the receiving county; and

iii. If the case is determined eligible, within five working days of that determination, transfer the case record material to the receiving county in accordance with (d)1i through iv below.

2. The receiving county has the responsibility to:

i. Communicate promptly with the client upon the receipt of the case material to advise of continued program entitlement; and

ii. Immediately notify the county of origin, in writing, of the date the case material was received.

(d) Eligible cases: For cases which are determined eligible for the Medicaid program:

1. The county of origin has the responsibility to:

i. Transfer, within five working days from the date it is notified of the actual move, a copy of pertinent case material to the receiving county. Such material shall include, at a minimum, a copy of the first application and most recent application form (including all verification), Social Security number(s), and the new address in the receiving county;

ii. Send with the above case material, a cover letter specifying that the case is being transferred and requesting written acknowledgement of receipt;

iii. Forward promptly to the receiving county, copies of any other material mutually identified as necessary for case administration; and

iv. Notify the receiving county if there will be a delay in providing any of the case material.

2. The receiving county has the responsibility to:

i. Communicate promptly with the client upon receipt of the case material;

ii. Immediately notify the county of origin, in writing, of the date the initial case material was received;

iii. Review eligibility for the case. If questions regarding case eligibility exist because of information provided by the county of origin, that county shall be consulted for resolution of the issues;

iv. Accept responsibility for the case (provided application to transfer has been made) effective with the next month if the initial case material has been received before the 10th of the month;

v. Accept responsibility for the case (provided application to transfer has been made) for the second month after the month of receipt of initial case material when such

material is received on or after the 10th of the month;

vi. Update the Medicaid Eligibility File as necessary including entry of a new case number. If the case is determined eligible for Medicaid in the receiving county, there shall be no interruption of entitlement. If the case is determined ineligible for Medicaid in the receiving county, eligibility shall be terminated, subject to timely and adequate notice, and the previously eligible person terminated on the Medicaid Eligibility File; and

vii. Notify the county of origin of the date eligibility for Medicaid will begin or will be terminated in the receiving county.

10:72-2.5 Redetermination of eligibility

(a) Eligibility for Medicaid under this chapter shall be redetermined, including the completion of the appropriate application form, as follows:

1. For a pregnant woman, eligibility need not be redetermined until the birth of her child. Upon the birth of the child, the newborn shall remain eligible for a period of not less than 60 days from his or her birth and up to one year, so long as the mother remains eligible, or would remain eligible if pregnant, and the child resides with her, whether or not application has been made.

2. For an aged, blind, or disabled individual, including a disabled child, eligibility must be redetermined no later than 12 months following the month of initial eligibility or the last redetermination using Form PA-1G-NJR2 (Redetermination Form). The CBOSS may require that the form be completed during a face-to-face interview. However, at the option of the CBOSS, and with the approval of the beneficiary, the face-to-face interview may be eliminated. Form PA-1G-NJR2 (Redetermination Form) may be mailed to and completed by the beneficiary and mailed to the CBOSS.

i. When a loss of assistance will result, the face-to-face interview shall be required, unless the agency documents a clear refusal by the beneficiary to have a face-to-face meeting. Before benefits are terminated, a beneficiary shall be offered a face-to-face home visit. The visit shall not be required to be in the office, but at the beneficiary's request, in the home.

(b) The county board of social services shall reassess program eligibility as follows:

1. When required on the basis of information the county board of social services has obtained previously about anticipated change in the case situation or when additional information is needed to ascertain income eligibility for the program.

2. Promptly after information is obtained by the county board of social services which indicates changes in the case circumstances that may affect program eligibility or post-eligibility treatment of income.

10:72-2.6 Post-application client responsibilities

(a) Upon a determination of eligibility for the Medicaid program, eligible persons have the on-going responsibility for the reporting of changes in family circumstances and for the provision of information as delineated at N.J.A.C. 10:72-2.1(c). Further, as

requested by the county welfare agency, additional information must be provided. At any time that the county welfare agency lacks sufficient information to confirm continuing program eligibility because of the unwillingness of an eligible person to provide necessary information, the agency shall commence action to terminate the case.

10:72-2.7 Retroactive eligibility

(a) Persons may be eligible under the provisions of this chapter for retroactive Medicaid eligibility for the three months preceding the month of application. Retroactive Medicaid coverage is available for any of the three months prior to application so long as eligibility existed and there are unpaid medical bills for services in that month. In the case of a pregnant woman, in order to be eligible for a retroactive month, the medical verification of pregnancy must have occurred in the retroactive month or in a previous month. In the case of a disabled or blind individual, the disability or blindness must be confirmed to have begun in a retroactive month or earlier.

(b) Determination of retroactive eligibility is the responsibility of the Division of Medical Assistance and Health Services. If the applicant has unpaid medical bills from the retroactive eligibility period, the county welfare agency shall provide the applicant with an Application for Payment of Unpaid Medical Bills (FD-74) and instruct the applicant to forward it to the Division of Medical Assistance and Health Services, Retroactive Eligibility Unit, PO Box 712, Trenton, New Jersey 08625-0712. An application for retroactive eligibility must be received by the Retroactive Eligibility Unit within six months of the date of application for Medicaid at the county welfare agency.
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END OF SUBCHAPTER 2

SUBCHAPTER 3. NONFINANCIAL ELIGIBILITY FACTORS

10:72-3.1 General provisions

(a) Eligibility for the Medicaid program must be established in relation to each requirement of the Medicaid program to provide a valid basis for the granting or denying of medicaid assistance.

(b) The applicant's statements regarding his or her eligibility, as set forth in the application form, are evidence. The statements must be consistent and meet prudent tests of credibility. Incomplete or questionable statements shall be supplemented and substantiated by corroborative evidence from other pertinent sources.

10:72-3.2 Citizenship

(a) In order to be eligible for the Medicaid program, an individual must be a citizen of the United States, an alien lawfully admitted for permanent residence, or an alien approved for temporary residence who can be classified as an eligible alien in accordance with this chapter.

1. The term "citizen of the United States" includes persons born in Puerto Rico, Guam, the Virgin Islands, Swain's Island, American Samoa, and the Northern Mariana Islands.
2. An individual who cannot be classified as an eligible alien in accordance with this subchapter due to changes mandated by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193) but who was residing in a Medicaid-certified nursing facility prior to January 29, 1997, shall continue to be eligible for medical assistance until the individual is no longer eligible for long-term care services.

(b) The following aliens, if present in the United States prior to August 22, 1996, and if otherwise meeting the eligibility criteria, are entitled to full Medicaid benefits:

1. An alien lawfully admitted for permanent residence;
2. A refugee admitted pursuant to section 207 of the Immigration and Nationality Act;
3. An asylee admitted pursuant to section 208 of the Immigration and Nationality Act;
4. An alien whose deportation has been withheld pursuant to section 243(h) of the Immigration and Nationality Act;
5. An alien who has been granted parole for at least one year by the Immigration and Naturalization Service pursuant to section 212(d)(5) of the Immigration and Nationality Act;
6. An alien who has been granted conditional entry pursuant to section 203(a)(7) of the immigration law in effect prior to April 1, 1980;
7. An alien who is granted status as a Cuban or Haitian entrant as defined by section 501(e) of the Refugee Education Assistance Act of 1980;

8. An American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act apply;

9. A member of an Indian tribe as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act;

10. An alien who is admitted to the United States as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988;

11. An alien who is honorably discharged or who is on active duty in the United States Armed Forces and his or her spouse and the unmarried dependent children of the alien or spouse; and

12. Certain legal aliens who are victims of domestic violence and when there is a substantial connection between the battery or cruelty suffered by an alien and his or her need for Medicaid benefits, subject to certain conditions described below:

i. The alien has been battered or subjected to extreme cruelty in the United States by a spouse or a parent.

ii. The alien has been battered or subjected to extreme cruelty in the United States by a member of the spouse's or parent's family residing in the same household of the alien and the spouse or parent acquiesced to such battery or cruelty.

iii. The alien's child has been battered or subjected to extreme cruelty in the United States by the spouse or the parent of the alien (without the active participation of the alien in the battery or cruelty).

iv. The alien's child has been battered or subjected to extreme cruelty in the United States by a member of the spouse's or parent's family residing in the same household as the alien and the spouse or parent acquiesced to and the alien did not actively take part in such battery or cruelty.

v. In addition to the conditions described in (b)12i through iv above, if the individual responsible for the battery or cruelty continues to reside in the same household as the individual who was subjected to such battery or cruelty, then the alien shall be ineligible for full Medicaid benefits.

vi. The county welfare agency shall apply the definitions "battery" and "extreme cruelty" and the standards for determining whether a substantial connection exists between the battery or cruelty and the need for Medicaid as issued by the Attorney General of the United States under his or her sole and unreviewable discretion, in accordance with 8 U.S.C. § 1641.

(c) The following aliens entering the United States on or after August 22, 1996, and if otherwise meeting the eligibility criteria, are entitled to Medicaid benefits:

1. An alien lawfully admitted for permanent residence but only after having been present in the United States for five years;

2. A refugee admitted pursuant to section 207 of the Immigration and Nationality Act;

3. An asylee admitted pursuant to section 208 of the Immigration and Nationality Act;

4. An alien whose deportation has been withheld pursuant to section 243(h) of the

Immigration and Nationality Act;

5. An alien who has been granted parole for at least one year by the Immigration and Naturalization Service pursuant to section 212(d)(5) of the Immigration and Nationality Act but only after the alien has been present in the United States for five years;

6. An alien who has been granted conditional entry pursuant to section 203(a)(7) of the immigration law in effect prior to April 1, 1980, but only after the alien has been present in the United States for five years;

7. An alien who is granted status as a Cuban or Haitian entrant pursuant to section 501(e) of the Refugee Education Assistance Act of 1980;

8. An American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act apply;

9. A member of an Indian tribe as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act;

10. An alien who is admitted to the United States as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988;

11. An alien who is honorably discharged or who is on active duty with the United States Armed Forces and his or her spouse and the unmarried dependent children of the alien or spouse; and

12. Certain aliens who are victims of domestic violence as specified in (b)12 above, but only after the alien has been present in the United States for five years.

(d) Persons claiming to be citizens and eligible aliens shall provide the county welfare agency with documentation of citizenship or alien status.

(e) As a condition of eligibility, all applicants for Medicaid (except for those applying solely for services related to the treatment of an emergency medical condition) shall sign a declaration under penalty of perjury that they are a citizen of the United States or an alien in a satisfactory immigration status. In the case of a child or incompetent applicant, another individual on the applicant's behalf shall complete the same written declaration under penalty of perjury.

1. The following shall be acceptable documentation of United States citizenship:

i. A birth certificate;

ii. A religious record of birth recorded in the United States or its territories within three months of birth. The document must show either the date of birth or the individual's age at the time the record was created;

iii. A United States passport (not including limited passports which are issued for periods of less than five years);

iv. A Report of Birth Abroad of a Citizen of the U.S. (Form FS-240);

v. A U.S. Citizen I.D. Card (INS Form-197), Naturalization Certificate (INS Form N-550 or N-570);

vi. A Certificate of Citizenship (INS Form N-560 or N-561);

vii. A Northern Mariana Identification Card (issued by the INS to a collectively naturalized citizen of the United States who was born in the United States before November 3, 1986);

viii. An American Indian Card with a classification code "KIC" (issued by the INS to identify U.S. citizen members of the Texas Band of Kickapoos); or

ix. A contemporaneous hospital record of birth in one of the 50 states, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam (on or after April 10, 1899), the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (unless the person was born to foreign diplomats residing in any of these jurisdictions).

2. If an applicant presents an expired INS document or is unable to present any document demonstrating his or her immigration status, the county welfare agency shall refer the applicant to the local INS district office to obtain evidence of status. If, however, the applicant provides an alien registration number, but no documentation, the county welfare agency shall file INS Form G- 845 along with the alien registration number with the local INS district office to verify status.

3. The following sets forth acceptable documentation for eligible aliens:

i. Lawful Permanent Resident--INS Form I-551, or for recent arrivals, a temporary I-551 stamp in a foreign passport or on Form I-94.

ii. Refugee--INS Form I-94 annotated with stamp showing entry as refugee under section 207 of the Immigration and Nationality Act and date of entry into the United States; INS Form I-688B annotated "274a. 12(a)(3)," I-766 annotated "A3," or I-571. Refugees usually adjust to Lawful Permanent Resident status after 12 months in the United States, but for purposes of determining Medicaid eligibility they are considered refugees. Refugees whose status has been adjusted will have INS Form I-551 annotated "RE-6," "RE-7," "RE-8," or "RE-9."

iii. Asylees--INS Form I-94 annotated with a stamp showing grant of asylum under section 208 of the Immigration and Nationality Act, a grant letter from the Asylum Office of the Immigration and Naturalization Service, Forms 688B annotated "274a. 12(a)(5)," or I-766 annotated "A5."

iv. Deportation Withheld--Order of an Immigration Judge showing deportation withheld under section 243(h) of the Immigration and Nationality Act and the date of the grant, or INS Form I-688B annotated "274a. 12(a)(10)" or I-766 annotated "A10."

v. Parole for at Least a Year--INS Form I-94 annotated with stamp showing grant of parole under section 212(d)(5) of the Immigration and Nationality Act and a date showing granting of parole for at least a year.

vi. Conditional Entry under Law in Effect before April 1, 1980--INS Form I- 94 with stamp showing admission under section 203(a)(7) of the Immigration and Nationality Act, refugee-conditional entry, or INS Forms I-688B annotated "274a. 12(a)(3)" or I-766 annotated "A3."

vii. Cuban Haitian Entrant--INS Form I-94 stamped "Cuban/Haitian Entrant under section 212(d)(5) of the INA."

viii. An American Indian born in Canada--INS Form I-551 with code S13 or an unexpired temporary I-551 stamp (with code S13) in a Canadian passport or on Form I-94.

ix. A member of certain Federally recognized Indian tribes--a membership card or other tribal document showing membership in tribe is acceptable documentation.

x. Amerasian Immigrant--INS Form I-551 with the code AM1, AM2, or AM3 or passport stamped with an unexpired temporary I-551 showing a code AN6, AM7, or AM8.

4. For aliens subject to the five-year waiting period before eligibility for Medicaid can be established, the date of entry into the United States shall be determined as follows:

i. On INS Form I-94, the date of admission should be found on the refugee stamp. If missing, the county welfare agency should contact the INS local district office by filing Form G-845, attaching a copy of the document;

ii. If the alien presents INS Form I-688B (Employment Authorization Document), I-766, or I-571 (Refugee Travel Document), the county welfare agency shall ask the alien to present Form I-94. If that form is not available, the county welfare agency shall contact the INS via the submission of Form G-845, attaching a copy of the documentation presented;

iii. If the alien presents a grant letter or court order, the date of entry shall be derived from the date of the letter or court order. If missing, the county welfare agency shall contact the INS by submitting a Form G-845, attaching a copy of the document presented.

5. For aliens who present themselves as on active duty or honorably discharged from the United States Armed Forces, the following shall serve as documentation:

i. For discharge status, an original, or notarized copy of the veteran's discharge papers issued by the branch of service in which the applicant was a member;

ii. For active duty military status, an original, or notarized copy, of the applicant's current orders showing the individual is on full-time duty with the U.S. Army, Navy, Air Force, Marine Corps, or Coast Guard (full-time National Guard duty does not qualify), or a military identification card (DD Form 2 (active));

iii. A self declaration under penalty of perjury may be accepted pending receipt of acceptable documentation.

10:72-3.3 State residency

(a) In order to be eligible for the Medicaid program, an individual must be a resident of the State of New Jersey. The term "resident" shall be interpreted to mean a person who is living in the State voluntarily and not for a temporary purpose, that is, with no intention of presently removing therefrom.

1. If an individual leaves New Jersey with the intent to establish permanent residence elsewhere, or for an indefinite period for purposes other than a temporary visit, he or she ceases to be eligible to receive Medicaid from this State.

2. When an individual enters this State in order to receive medical care and applies for

Medicaid to meet all or a portion of the costs of such care, the fact that the immediate purpose of the move was to secure medical care does not, in and of itself, have the effect of making the person ineligible for the Medicaid program. It is the responsibility of the county welfare agency to evaluate all such cases and to make an eligibility determination, considering carefully all the following criteria:

i. Whether the move is a temporary one, being solely for the purpose of receiving medical care for a limited time;

ii. Whether there is clear expression of intent on the part of the individual to remain permanently in this State;

iii. Whether there is objective evidence that the individual has, in fact, abandoned or not abandoned residence in the State from which he or she came;

iv. Whether the state in which the individual previously resided recognizes him or her as having continuing eligibility under the Medicaid program (or other program providing payment for medical care) of that jurisdiction.

3. If, after full consideration of the above factors, the county welfare agency is satisfied that the individual has become a resident of this State, Medicaid eligibility may be established.

10:72-3.4 Eligible persons

(a) The following persons who meet all eligibility criteria of this chapter are eligible for Medicaid benefits:

1. Pregnant women: Needy women of any age during the term of a medically verified pregnancy.

i. A woman who is determined eligible under the criteria of this chapter will, for purposes of eligibility, be considered to be a pregnant woman until the end of the 60-day period beginning with the last day of her pregnancy. Her eligibility as a pregnant woman shall end on the last day of the month in which the 60-day period ends.

2. Children under the age of one.

3. A child born to a woman eligible under the provisions of this chapter (except to a presumptively eligible pregnant woman who has subsequently been found ineligible for the month the child was born) shall remain eligible for a period of not less than 60 days from his or her birth and up to one year, so long as the mother remains eligible for Medicaid, or would remain eligible if pregnant, whether or not application has been made, if the child lives with his or her mother. This also applies to an infant born to a mother whose labor and delivery were covered by Medicaid as emergency services even though the mother cannot receive Medicaid services except for emergency services.

4. Any child receiving Medicaid under the provisions of this chapter who but for the age limits in (a)2 above would be eligible for Medicaid under the provisions of this chapter and who is receiving inpatient services covered by Medicaid at the time he or she reaches the age limit, will continue to be eligible for Medicaid until the end of the stay for which the inpatient services are furnished.

5. Aged individuals: Persons who are age 65 years or older.

6. Disabled individuals: Persons who have been medically determined to meet the criteria of disability as set forth at N.J.A.C. 10:71-3.10 through 3.13.

7. Blind individuals: Persons who have been medically determined to meet the criteria of blindness as set forth at N.J.A.C. 10:71-3.10 through 3.13.

10:72-3.5 Household unit

(a) The term "household unit" means those persons whose income is counted in the determination of eligibility under the provisions of this chapter. The following persons, if they reside with the program applicant or beneficiary, shall be considered members of the household unit:

1. In the case of a pregnant woman:

i. The pregnant woman and the unborn child (or children, when it is medically verified that there is more than one fetus);

ii. The pregnant woman's spouse;

iii. The pregnant woman's natural or adoptive children under the age of 21;

iv. The blood-related siblings (including those of half-blood) of the pregnant woman's children who are under the age of 21; and

v. The natural or adoptive father of any children in the household unit.

2. In the case of an infant:

i. The child;

ii. The child's natural or adoptive parents;

iii. The child's blood-related (including half-blood) and adoptive siblings under the age of 21; and

iv. At the option of the applicant, the child's stepparent. If the applicant elects not to include the stepparent in the household unit, his or her income will not be included in the determination of eligibility except to the extent that he or she makes it available to the eligible members.

3. In the case of an aged, blind, or disabled individual, the household unit will consist of that individual and his or her spouse if the spouse resides with the aged, blind, or disabled individual. In the case of a blind or disabled child, the household unit will consist of only that child; however, the income and resources of the child's parents will be deemed to that child in accordance with N.J.A.C. 10:72-4.4(d).

4. Any person who is in receipt of Work First New Jersey/TANF or SSI or who has applied for and been found eligible for Medicaid based on eligibility for those cash assistance programs will not be included in the household unit. Any person whose income and resources have been deemed to an eligible SSI beneficiary shall likewise not be included in the household unit unless that person is applying for benefits under this chapter.

5. Any person in (a)1 and 2 above shall be included in the household unit even though he or she is in an AFDC-related Medically Needy budget unit in accordance with N.J.A.C. 10:70-3.5. Likewise, any person in (a)1 and 2 above required by N.J.A.C.

10:70-3.5 to be included in an AFDC-related Medically Needy budget unit, shall be included in that budget unit even if he or she is included in a household unit under the provisions of this section. Any aged, blind, or disabled person eligible under the provisions of this chapter or who is eligible for Medically Needy (or pending spend-down) will not be included in the household unit of a pregnant woman or child.

6. A spouse shall not be included in the household unit of an aged, blind, or disabled individual if the spouse is himself or herself in the household unit of an eligible pregnant woman or infant under the provisions of this chapter, or is in the budget unit of an eligible AFDC-related Medically Needy case (including eligible pending spend-down). Note: Resources of a spouse of an aged, blind, or disabled individual will be deemed to that individual in accordance with N.J.A.C. 10:72-4.5 even though the spouse is not in the household unit.

10:72-3.7 Persons sanctioned under AFDC rules

Persons who would be ineligible for AFDC using the rules in existence as of July 16, 1996 or due to the imposition of a sanction of ineligibility for a factor of AFDC eligibility that does not apply in Medicaid (such as noncooperation with work registration or WIN requirements) shall have eligibility determined under this chapter without regard to the sanction. (For persons ineligible for AFDC due to a period of ineligibility imposed as a result of the receipt of lump sum income, see N.J.A.C. 10:72-4.3(c)).

10:72-3.8 Application for other benefits

(a) As a condition of eligibility for the Medicaid program, applicants and beneficiaries are required to take all necessary steps to obtain any annuities, pensions, retirement and disability benefits to which they are entitled, unless they can show good cause for not doing so. Applicants and beneficiaries must avail themselves of any health insurance coverage available to the household unit at no cost, such as coverage provided by an employer at no cost.

1. Annuities, pensions, retirement and disability benefits include, but are not limited to, veterans' compensation and pensions, Social Security benefits, and unemployment compensation. They do not include AFDC, Supplemental Security Income (SSI), or General Assistance.

10:72-3.9 Inmates of public institutions

(a) Any person who is an inmate of a public institution is ineligible for the Medicaid program.

(b) Any person who is incarcerated in a Federal, State, or local correction facility (prison, jail, detention center, reformatory, etc.) is not eligible for the Medicaid program.

10:72-3.10 Emergency services for aliens and routine prenatal care for specified aliens

(a) Any alien who is not an eligible alien as specified in N.J.A.C. 10:72- 3.2(c) and (d), shall be ineligible for Medicaid benefits. Any such alien shall be, if a resident of New Jersey and if he or she meets all other Medicaid eligibility requirements, entitled to Medicaid coverage for the treatment of an emergency medical condition only.

1. An emergency medical condition is one of sudden onset that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:
   i. Placing the patient's health in serious jeopardy;
   ii. Serious impairment to bodily functions; or
   iii. Serious dysfunction of any bodily organ or part.

2. An emergency medical condition shall include all labor and delivery for a pregnant woman. It does not include routine prenatal or post-partum care.

3. Services related to an organ transplant procedure are not covered under services available for treatment of an emergency medical condition.

(b) Limited prenatal care shall be provided by the Division to alien pregnant women who would be eligible for New Jersey Care ... Special Medicaid Programs or NJ FamilyCare services but for their immigration status. Services available through NJSPCP shall be limited to pregnancy-related services provided at a clinic or at a hospital, and shall include primary care, radiology, and clinical laboratory services or, in the case of radiology and clinical laboratory services, ordered by a clinic. In addition, pregnancy-related pharmaceuticals dispensed at a clinic or a hospital are covered. No other services shall be provided.

1. Services available through NJSPCP shall be limited to pregnancy-related services provided at a clinic or at a hospital, including primary care, radiology, and clinical laboratory services, or, in the case of radiology and clinical laboratory services, ordered by a clinic. In addition, pregnancy- related pharmaceuticals dispensed at a clinic or a hospital shall be covered. No other services shall be provided. Services eligible for reimbursement shall be directly related to the beneficiary's primary diagnosis. The eligible beneficiary's primary diagnosis shall be one or more of the pregnancy-related diagnostic codes 640 through 648.9 or V22 through V23.89, as found in the ICD-9-CM (International Classification of Diseases).
   i. Labor and delivery services shall not be covered by the NJSPC program, but may be provided through the Medical Emergency Payment Program for Aliens, in accordance with the provisions of N.J.A.C. 10:49-5.4.

2. Eligible services, as described in (b)1 above, shall be reimbursed if the services were rendered to an eligible individual on or after July 1, 2001 and before the termination of the NJSPC program.

3. When the appropriated funds have been expended, the program will terminate.

END OF SUBCHAPTER 3

SUBCHAPTER 4. FINANCIAL ELIGIBILITY

10:72-4.1 Income eligibility limits

(a) Income limits for Medicaid for aged, blind, and disabled persons (except for specified low-income Medicare beneficiaries), covered under the provisions of this chapter will be based on 100 percent of the poverty income guidelines as defined by the U.S. Department of Health and Human Services in accordance with sections 652 and 673(2) of the Omnibus Budget Reconciliation Act of 1981 (Pub.L. 97-35). The monthly income standard will be 1/12 of the annual poverty income guideline rounded down to the next whole dollar amount for household unit sizes of one and two for aged, blind, and disabled individuals. The annual revision to the Federal poverty income guideline will be effective for purposes of this section with the first day of the year for which the poverty income guideline is promulgated.

(b) Effective with the first month of coverage, January 1, 1993, income limits for specified low-income Medicare beneficiaries shall be based on 110 percent of the poverty income guidelines as defined by the U.S. Department of Health and Human Services in accordance with Sections 1902(a)(10)(E)iii of the Social Security Act, 42 U.S.C. 1396a. Effective January 1, 1995, the income limits will be set at 120 percent of the Federal poverty level.

(c) Income limits for pregnant women and children under the age of one year covered under the provisions of this chapter shall be based on 185 percent of the poverty income guideline as defined by the Department of Health and Human Services in accordance with sections 652 and 673(2) of the Omnibus Budget Reconciliation Act of 1981 (Pub.L. 97-35). The monthly income standard will be one-twelfth of 185 percent of the annual poverty income guideline rounded down to the next whole dollar amount for each household size. The annual revision to the Federal poverty income guideline will be effective for the purposes of this section with the first day of the year for which the poverty guideline is promulgated.

(d) In order to be eligible for Medicaid benefits under the provisions of this chapter, monthly household income (as determined by this chapter) must be equal to or less than the income limit established in (a), (b) or (c) above as applicable.

1. If a pregnant woman is determined to be income eligible during any month prior to the end of her pregnancy, she, if otherwise eligible, will continue eligible without regard to changes in the household unit's income for the term of her pregnancy, including the 60-day period beginning with the last day of the pregnancy whether or not the pregnancy results in a live birth. If the income change results from the addition of a new household member, the new income is not considered through the 60-day period beginning with the last day of the pregnancy.

i. The child resulting from the pregnancy will be eligible for Medicaid without regard to

changes in the household unit's income for a period of not less than 60 days and up to a period of one year, so long as the mother remains eligible for Medicaid, or would remain eligible if pregnant, and the child remains in the mother's custody.

ii. A pregnant woman who, during the course of the pregnancy, was receiving or would have been eligible to receive AFDC benefits using the eligibility rules in existence as of July 16, 1996. Medicaid Special, or Medicaid for the Unborn is deemed to have met the income requirements of this chapter.

2. With the exception in (d)1 above, income eligibility exists for each month in which the household unit's income is equal to or less than the income limits.

10:72-4.2 Prospective budgeting of income

(a) The county welfare agency shall establish the best estimate of income that will be available to the household unit.

1. The best estimate of income shall be based on an average of the household unit's income for the full two-month period preceding the date of application or redetermination. Adjustments shall be made to the estimated income to reflect changes in income that either have occurred or which are reasonably anticipated to occur which would affect the household unit's income during a period of eligibility.

10:72-4.3 Countable income; pregnant women and infants

(a) Except as specified below, countable income for pregnant women and infants under the provisions of this chapter shall include the income of all members of the household unit as determined at N.J.A.C. 10:72-3.5(a)1 and 2, and shall be determined in accordance with regulations applicable to income in the AFDC-C program in effect as of July 16, 1996 (see N.J.A.C. 10:82).

1. The maximum income limits as provided for at N.J.A.C. 10:82-1.2(d) do not apply.

2. Neither the $30.00 nor the one-third disregard of earned income at N.J.A.C. 10:82-2.8(a)3 and 10:82-4.4(c) apply.

3. The deeming of stepparent income at N.J.A.C. 10:82-2.9(d) does not apply. (See N.J.A.C. 10:72-3.5(a)2 regarding the inclusion or exclusion of the stepparent in the household unit.)

4. The deeming of an alien sponsor's income at N.J.A.C. 10:82-3.13 does not apply.

(b) Nonrecurring lump sum income received by a household unit of a pregnant woman or infant shall be added to any other income received by the household unit in that month. The total shall be divided by the income eligibility limit applicable to the household. The result will be the number of months the eligible members of the household unit shall be ineligible to receive Medicaid under the provisions of this chapter. Any remaining income from this calculation is treated as if it were unearned income in the first month following the period of ineligibility. No period of ineligibility shall apply to a pregnant women eligible under the provisions of this chapter.

1. The period of ineligibility shall begin the first month subsequent to the month the

nonrecurring income is received or, if there is insufficient time to provide timely adverse action notice, the following month.

2. Once established, the period of ineligibility may be reduced only in accordance with the AFDC provisions for shortening a period of ineligibility as found at N.J.A.C. 10:82-4.15(a)5. The basis for a determination to shorten the period of ineligibility shall be fully documented in the case record.

(c) Any person who received AFDC or Medicaid based on AFDC rules and became ineligible for such assistance because of a period of ineligibility imposed as a result of the provisions of N.J.A.C. 10:82-4.15 may establish eligibility under the provisions of this chapter. The amount of the lump sum used to determine the original period of ineligibility shall be divided by the applicable income eligibility limit to determine the period of ineligibility for Medicaid under this chapter. If that period has already expired, eligibility for benefits under this chapter may be established so long as all other eligibility criteria are met.

(d) The parents of an infant and the spouse of a pregnant woman are legally responsible relatives to pregnant women and infants applying for or eligible for benefits under the provisions of this chapter. When a legally responsible relative resides in the same household, his or her income is considered in the determination of eligibility and no further action is required. When a legally responsible relative does not reside in the same household, the county welfare agency shall pursue support from that relative in accordance with the provisions of N.J.A.C. 10:82-3.8 et seq.

1. Except when the legally responsible relative resides in the same household, income of the relative shall be counted only to the extent that the income is actually made available to the household unit.

(e) No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility purposes.

10:72-4.4 Income eligibility; aged, blind, and disabled individuals

(a) Except as specified below, countable income for aged, blind, and disabled individuals shall be determined in accordance with rules applicable to income in Medicaid Only--Aged, Blind, and Disabled (see N.J.A.C. 10:71-5).

1. The disregard of cost-of-living increases in Social Security benefits provided for in N.J.A.C. 10:71-5.3(a)7x and xi do not apply.

2. The deeming of the income of an alien's sponsor as provided for at N.J.A.C. 10:71-5.7 does not apply.

(b) Nonrecurring lump sum income received by the household unit of an aged, blind, or

disabled individual shall be counted as income in the month received and any portion retained shall be counted as a resource in subsequent months, except as follows:

1. No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility process;

(c) An aged, blind, or disabled individual will have the value of in-kind support and maintenance counted as unearned income in the following circumstances.

1. An aged, blind, or disabled adult, who would in accordance with rules at N.J.A.C. 10:71-5.6(c) be determined to be "living in the household of another," shall be considered to have unearned income in the amount specified at N.J.A.C. 10:71-5.4(a)12 less $20.00. The amount of income so assigned is not rebuttable by the applicant or beneficiary.

2. Any aged, blind, or disabled person other than those addressed in (c)1 above, to whom food, clothing, or shelter is given or paid for by someone other than a spouse, parent, or minor child residing in the same household, shall be presumed to receive in-kind support and maintenance. The presumed value of the support and maintenance will be the values specified at N.J.A.C. 10:71-5.4(a)12. The presumed value so assigned may be rebutted in accordance with the provisions of that subsection.

(d) In accordance with the rules at N.J.A.C. 10:71-5.5, the income of the spouse of an aged, blind, or disabled individual shall be deemed to the aged, blind, or disabled individual if they are residing in the same household. Income of the parent(s) of a blind or disabled child under the age of 18 residing in the same household shall be deemed available to the child in determining income eligibility for benefits under this chapter. No income shall be deemed to an aged, blind, or disabled individual from a person who is a member of a household unit of an eligible pregnant woman or child under the provisions of this chapter or who is in the budget unit of eligible AFDC- related Medically Needy cases (including a case that is eligible pending spend- down.)

1. If the countable income (before income deeming) of the aged, blind, or disabled individual exceeds the poverty income guideline for one person he or she is ineligible for benefits and income deeming does not apply.

2. When income of a spouse is deemed to an aged, blind, or disabled individual, the total countable income after deeming is compared to the poverty income guideline for two persons.

3. In determining income eligibility of a child, the child's income after deeming is compared to the poverty income guideline for one person.

4. When the income of a spouse must be deemed to both an aged, blind, or disabled individual and a blind or disabled child, the income is first deemed to the aged, blind, or disabled spouse. If the income (after deeming) of the aged, blind, or disabled spouse does not exceed the poverty income guideline, he or she is income eligible and there is

no income to be deemed to the blind or disabled child. If the poverty income guideline is exceeded, the aged, blind, or disabled adult is income ineligible and the excess income is deemed to the blind or disabled child.

5. When parental income must be deemed to more than one blind or disabled child, the deemable income shall be divided equally among such children.

10:72-4.5 Resource eligibility

(a) Pregnant women and infants seeking Medicaid benefits under the provisions of this chapter are eligible without regard to the value of the household unit's resources. The county welfare agency shall inquire about the household unit's resources only in order to establish income that may result from the household unit's resources.

(b) Aged, blind or disabled persons (including specified low-income Medicare beneficiaries) must meet resource eligibility criteria as specified below in order to be eligible for benefits under this chapter. Eligibility for benefits does not exist in any month in which the countable resources of an aged, blind, or disabled person exceeds the limits of $4,000 for an individual and $6,000 for a couple.

1. The resource provisions of the Medicaid Only Manual apply in the determination of countable resources for aged, blind, or disabled individuals except that, the provisions requiring the deeming of the resources of an alien's sponsor (N.J.A.C. 10:71-4.6(f)) do not apply in this chapter.

2. The spouse-to-spouse and parent-to-child deeming of resources found at N.J.A.C. 10:71-4.6 apply to eligibility under this chapter. In the deeming of resources from one parent to a child, the countable parental resources in excess of the Medicaid Only resource limit for an individual shall be deemed to the blind or disabled child. When the resources of two parents must be deemed to a child, the countable parental resources in excess of the Medicaid Only resource limit for a couple shall be deemed to the child.

3. For aged, blind, or disabled persons, the policy concerning transfer of resources within 30 months of the date of application (see N.J.A.C. 10:71- 4.7), applies equally to eligibility under this chapter.

(c) No portion of a cash reward provided to any individual by the Division for providing information about fraud and/or abuse in any program administered in whole or in part by the Division shall be included in the computation of income for financial eligibility purposes.

1. In order for the case reward to continue to be excluded, the funds shall be separately identifiable (that is, not commingled with other funds or assets), but held in a separate account. Any increase in the value of the excluded case reward shall also be excluded.

END OF SUBCHAPTER 4

SUBCHAPTER 5. ADMINISTRATIVE REQUIREMENTS

10:72-5.1 Notice of the county welfare agency decision

(a) The county welfare agency shall promptly notify any applicant for, or beneficiary of, the Medicaid program in writing of any agency decision affecting the applicant or beneficiary. When a decision relates to any adverse action which may entitle a beneficiary to a fair hearing, the action may not be implemented until at least 10 days after the mailing of the notice (see (e) below for exceptions to the 10-day notice requirement).

1. For notices of action adverse to a beneficiary, the date of mailing of the notice must appear on the notice.
2. Notices of any county welfare agency action must contain the name, address, and telephone number of the legal services agency serving that county.
3. In the case of an applicant or beneficiary who cannot be located, the notice shall be mailed to his or her last known address.

(b) All notices of agency decision shall state in clear and simple language, the nature of the agency decision and an accurate and factual legal basis for the decision.

1. All notices of the agency decision shall include an explanation of the right to a fair hearing.
2. Notices of agency decisions adverse to the applicant or recipient shall include the citation and title of the regulations upon which the agency decision is based.

(c) All notices of denial or termination shall include an explicit statement of the reason for program ineligibility and (except in the case of the death of an applicant or beneficiary) advise of the right to reapply whenever the applicant or beneficiary believes that circumstances have changed such that the reason for program ineligibility no longer exist.

(d) When the processing of an application will be delayed beyond the standards for disposition of an application as set forth in N.J.A.C. 10:72- 2.1(d), notice shall be mailed prior to the expiration of the disposition period notifying the applicant of the delay and the reasons for it.

(e) The 10-day notice requirement for actions adverse to a program beneficiary need not be adhered to when:

1. The county welfare agency has factual information confirming the death of a beneficiary;
2. The county welfare agency receives a clear written statement, signed by the beneficiary, that he or she no longer wishes to receive program benefits, or which gives information indicating a change in circumstances which requires a termination or reduction in benefits, and the beneficiary has indicated in writing that he or she

understands that this must be the consequence of supplying such information;

3. The beneficiary's whereabouts are unknown and agency mail directed to him or her has been returned by the postal service indicating no forwarding address;

4. The beneficiary has been accepted for public or medical assistance in another state and that fact has been confirmed by the county welfare agency; or

5. A beneficiary child has been removed from the home as a result of a judicial determination or voluntarily placed in foster care by his or her legal guardian.

10:72-5.2 Fair hearings

(a) It is the right of every applicant for or beneficiary of the Medicaid program to be afforded the opportunity for a fair hearing in the manner set forth in N.J.A.C. 10:49-51 et seq., including, when applicable, continuation of program benefits pending the results of the fair hearing.

(b) Any request for a fair hearing shall be forwarded to the Division of Medical Assistance and Health Services, Office of the Legal and Regulatory Liaison, PO Box 712, Trenton, New Jersey 08625-0712.

10:72-5.3 Case records

(a) The purpose of the case record is to provide a complete documentary record of county welfare agency actions and the reasons therefor.

(b) The case record shall include:

1. A record of all county welfare agency actions and decisions relating to the case, as well as documentary evidence relating to such actions and decisions, including application forms.

2. All forms relating to financial eligibility.

3. All case-related correspondence, memorandum, and documents except those required by law or regulation to be maintained elsewhere.

(c) No case record, or part thereof, shall be removed from its file location without a record identifying the person who has custody of it.

(d) No case record, or part thereof, shall be removed from the county welfare agency offices except upon the specific authorization of the agency director, deputy director, or other person specifically designated by the agency director to authorize such removal.

(e) All case records shall be filed in a secure and fire-resistant location.

END OF SUBCHAPTER 5

SUBCHAPTER 6. PRESUMPTIVE ELIGIBILITY

10:72-6.1 Scope

(a) The presumptive eligibility determination makes it possible for a pregnant woman to receive ambulatory prenatal care from a Medicaid participating provider for a temporary period prior to application for Medicaid benefits and while a Medicaid application is being processed by the county welfare agency. Presumptive eligibility continues until the county welfare agency reaches its formal eligibility determination as follows:

1. The period of presumptive eligibility begins on the date a qualified provider determines that, based on information provided by the pregnant woman, the woman meets the requirements and standards of this chapter applicable to pregnant women.
2. The period of presumptive eligibility will terminate:
   i. If the woman has filed an application with the county welfare agency, on or before the last day of the month subsequent to the month in which she was determined presumptively eligible, or on the date a determination of eligibility or ineligibility for Medicaid is made by the county welfare agency; or
   ii. If the pregnant woman fails to file an application with the county welfare agency, on the last day of the month subsequent to the month in which she was determined presumptively eligible.

(b) A qualified provider shall be:

1. A participating Medicaid provider;
2. Currently certified by the New Jersey Department of Health as a provider of HealthStart Comprehensive Maternity Care Services (see N.J.A.C. 10:49- 3). A provider certified only for Medical Maternity Care Services, Health Support Services, or Pediatric Preventive Services shall not be a qualified provider for purposes of this subchapter;
3. A provider of the following services:
   i. Outpatient hospital services; or
   ii. Clinic services furnished by or under the direction of a physician, without regard to whether or not the clinic itself is administered by a physician; and
4. Trained and approved by the Division of Medical Assistance and Health Services for the purposes of making presumptive eligibility determinations.
   i. The Division of Medical Assistance and Health Services will monitor the presumptive eligibility determinations made by qualified providers. In the event the review discloses a pattern of incorrect presumptive eligibility determinations or failure to adhere to procedural requirements, appropriate staff of the Division will initiate corrective action. Continued incorrect presumptive eligibility determinations or failure to adhere to procedural requirements will result in the Division revoking approval for that provider to make presumptive eligibility determinations.

10:72-6.2 Responsibilities of a qualified provider

(a) From preliminary information provided by a woman whose pregnancy has been medically verified, the qualified provider shall determine if the pregnant woman meets the eligibility criteria of this chapter as it applies to pregnant women. The qualified provider must obtain sufficient information from the pregnant women to complete the Certification of Presumptive Eligibility (FD- 334) by having the pregnant women complete, sign and date a referral for Medicaid benefits as designated and provided by the Division of Medical Assistance and Health Services. For purposes of the presumptive eligibility determination, the qualified provider shall request from the pregnant woman only that information necessary to determine her presumptive eligibility or ineligibility. The qualified provider shall make the determination of eligibility based solely on information obtained in the interview and shall not require any verification or documentation of the pregnant woman's statements.

1. For any pregnant woman determined presumptively eligible, the qualified provider shall complete and sign the FD-334. The completed FD-334 together with the pregnant woman's New Jersey Care Pregnant Women and Infants Application Referral (FD-335) for Medicaid shall be mailed or otherwise forwarded to the county welfare agency of the pregnant woman's county of residence within two working days of the presumptive eligibility determination. The qualified provider shall also forward a copy of the pregnant woman's Certification of Presumptive Eligibility (FD-334) to the Division of Medical Assistance and Health Services. The qualified provider shall inform the pregnant woman that her presumptive eligibility provides only limited services for a period of time not to exceed the length of the presumptive eligibility period, and that she must contact the county welfare agency in order to set up an appointment to complete the application process for Medicaid benefits. The qualified provider shall give the presumptively eligible pregnant woman a copy of both the Certification of Presumptive Eligibility (FD-334) and her New Jersey Care Pregnant Women and Infants Application Referral (FD-335) for Medicaid benefits. The qualified provider shall advise the presumptively eligible pregnant woman, in writing, of the address and telephone number of the appropriate county welfare agency office.

2. For any woman for whom the qualified provider is unable to determine presumptive eligibility or who is ineligible under the criteria and standards of this chapter as it applies to pregnant women, the qualified provider shall refer the woman to the county welfare agency for evaluation of potential eligibility for Medically Needy or other Medicaid entitlement. The address and telephone number of the appropriate county welfare agency office shall be provided, in writing, to the pregnant woman.

10:72-6.3 Responsibility of the Division of Medical Assistance and Health Services

(a) Upon receipt of a properly completed Certification of Presumptive Eligibility (FD-334) from the qualified provider, Division staff shall:

1. Assign a presumptive eligibility number from a log of unissued numbers:
2. Create an eligibility record on the Medicaid Eligibility File;

3. Issue a Medicaid Eligibility Identification (MEI) Card; and

4. Notify the qualified provider and the appropriate county welfare agency of the presumptive eligibility identification number assigned to the beneficiary.

10:72-6.4 Responsibility of the county welfare agency

(a) Upon receipt of the Certification of Presumptive Eligibility (FD-334) and a properly completed New Jersey Care Pregnant Women and Infants Application Referral (FD-335) from the qualified provider, the county welfare agency shall:

1. Check the Medicaid and Medically Needy Eligibility File for existing Medicaid eligibility.

i. If the beneficiary is receiving Medicaid benefits as an AFDC child or adult, a Medicaid Special individual, or a New Jersey Care or Medically Needy pregnant woman, no further action shall be required by the county welfare agency.

ii. If the beneficiary is receiving Medicaid benefits as a Medically Needy child or Medically Needy disabled adult, a separate case shall be established which would entitle the beneficiary to receive additional prenatal services available to Medically Needy pregnant women. In such instances, the county welfare agency shall schedule a face-to-face interview with the beneficiary to verify all factors of eligibility before a final determination of eligibility or ineligibility is made.

iii. If the beneficiary is an AFDC adult or child, and there are indications of a change in circumstances, such as a marriage of the pregnant woman, the county welfare agency may schedule a face-to-face interview with the beneficiary to verify all factors of continued eligibility as an AFDC case before a final determination of eligibility or ineligibility is made. However, she cannot be found ineligible for Medicaid solely because she does not meet AFDC standards for cash assistance, but must be evaluated for eligibility for other Medicaid programs without regard to any changes which occurred after the determination of presumptive eligibility.

2. Notwithstanding the application disposition standards in N.J.A.C. 10:72-2.1(d), the county welfare agency shall arrive at a case disposition within the presumptive eligibility period.

i. The policy at N.J.A.C. 10:72-2.1(d)2 concerning delayed application processing applies equally to the processing of the application of a presumptively eligible pregnant woman. In the event the processing standard is exceeded, the qualified provider shall be notified that the processing of the woman's Medicaid application has been delayed. The Division of Medical Assistance and Health Services shall also be notified of any such delay, and shall take steps to continue her presumptive eligibility until a final determination is made.

ii. In the event the processing of the application is delayed beyond the presumptive eligibility period, the county welfare agency shall provide the applicant with written notification prior to its expiration setting forth the specific reasons for the delay.

3. In the case of a presumptively eligible pregnant women who is determined ineligible for Medicaid within the presumptive eligibility period, the woman's eligibility shall

terminate as of the day of the ineligibility determination.

10:72-6.5 Responsibility of the applicant

A presumptively eligible pregnant woman must contact the county welfare agency during the presumptive eligibility period so that a face-to-face interview can be scheduled. As part of the eligibility determination process for Medicaid, the pregnant woman must be interviewed by county welfare agency staff, complete any forms required as a part of the application process, and assist the county welfare agency in securing evidence that verifies her statements regarding eligibility.

10:72-6.6 Notification and fair hearing rights

(a) For a presumptively eligible pregnant woman who is subsequently determined ineligible for Medicaid benefits:

1. The county welfare agency is not required to provide either timely or adequate notice for the end of the presumptive eligibility. The pregnant woman has no right to a fair hearing based on the termination of her presumptive eligibility.
2. The county welfare agency shall provide the applicant notice of denial of her Medicaid application in accordance with N.J.A.C. 10:72-5.1. The pregnant woman has the right to apply for a fair hearing based on the denial of her Medicaid application.

(b) For a presumptively eligible pregnant woman whose eligibility for Medicaid has not yet been determined within the presumptive eligibility period:

1. The county welfare agency is not required to provide either adequate or timely notice for the termination of her period of presumptive eligibility. The pregnant woman has no right to a fair hearing based on the termination of presumptive eligibility.
2. In accordance with N.J.A.C. 10:72-2.1(d)3, the county welfare agency shall provide the pregnant woman with written notification prior to the expiration of the presumptive eligibility period, setting forth the specific reasons for the delay in the Medicaid application processing. The pregnant woman is entitled to a fair hearing based on the county welfare agency's failure to determine her Medicaid eligibility or ineligibility within the application processing period.

(c) A woman denied presumptive eligibility by a qualified provider is neither entitled to adequate notice of that determination nor entitled to a fair hearing on that action. The denial of presumptive eligibility shall not affect the woman's right to apply for Medicaid at the county welfare agency and to receive a formal determination of eligibility or ineligibility.

END OF SUBCHAPTER 6

SUBCHAPTER 7. PRESUMPTIVE ELIGIBILITY FOR CHILDREN

10:72-7.1 Scope

This subchapter describes the presumptive eligibility process for children, up to the age of one year, who may meet the eligibility requirements for New Jersey Care ... Special Medicaid Programs. The presumptive eligibility determination makes it possible for a child or the children in a family to receive fee-for-services care from a Medicaid participating provider for a temporary period prior to the application for New Jersey Care ... Special Medicaid Programs benefits, and while an application for these benefits is being processed by the eligibility determination agency.

10:72-7.2 Period of presumptive eligibility

(a) The period of presumptive eligibility shall begin on the date an approved presumptive eligibility entity determines that, based on information provided by the family of the presumptive eligibility beneficiary, the child(ren) meets the requirements and standards of this chapter.

(b) The period of presumptive eligibility shall terminate:

1. On the date a determination of eligibility or ineligibility for New Jersey Care ... Special Medicaid Programs is made; or
2. If the child's parent, guardian, or caretaker relative fails to file an application with the applicable eligibility determination agency, on the last day of the month subsequent to the month in which the child(ren) was (were) determined presumptively eligible.

10:72-7.3 Presumptive eligibility determination entities

(a) A qualified presumptive eligibility entity shall be a New Jersey Medicaid provider and:

1. An acute care hospital;
2. A local health department; or
3. A Federally Qualified Health Center (FQHC).

(b) An eligible entity shall apply to the Division of Medical Assistance and Health Services and shall be approved as a presumptive eligibility determination agency upon training of the entity by the Division of Medical Assistance and Health Services.

(c) The Division of Medical Assistance and Health Services shall monitor the presumptive eligibility determinations made by approved presumptive eligibility determination entities. If the review discloses a pattern of incorrect presumptive eligibility determinations or failure to adhere to requirements, the Division shall initiate corrective action, including, but not limited to, consultation and training. Continued incorrect presumptive eligibility determinations or failure to adhere to procedural requirements shall result in the Division revoking approval for that entity to make

presumptive eligibility determinations.

10:72-7.4 Policies governing the presumptive eligibility processing performed by the presumptive eligibility determination entity

(a) From preliminary information provided by a parent, guardian, or caretaker relative, the approved presumptive eligibility entity shall determine if the child meets the eligibility criteria of this subchapter as it applies to children. The approving presumptive eligibility entity shall obtain sufficient information from the parent, guardian, or caretaker relative to complete the certificate of presumptive eligibility. For purposes of the presumptive eligibility determination, the approved presumptive eligibility determination entity shall request from the parent, guardian, or caretaker relative only that information necessary to determine the child's presumptive eligibility or ineligibility. The approved presumptive eligibility determination entity shall make the determination of eligibility based solely on information obtained in the interview and shall not require any verification or documentation of the presumptive eligibility beneficiary's statements.

(b) For any child determined presumptively eligible, the approved presumptive eligibility determination entity shall:

1. Complete and sign the certificate of presumptive eligibility and forward the original of the certificate of presumptive eligibility to the Division of Medical Assistance and Health Services within two working days of the date the presumptive eligibility determination was made;
2. Forward a copy of the completed certificate and the referral, if appropriate, to the eligibility determination agency of the applicant's choice;
3. Inform the parent, guardian, or caretaker relative that they must contact the eligibility determination either by mailing an application to the Statewide eligibility determination agency or by arranging for a face-to-face interview with the county board of social services in order to complete the application process;
4. Give the parent, guardian, or caretaker relative of the presumptively eligible child a copy of both the certificate and the referral, if completed; and
5. Advise the parent, guardian, or caretaker relative of the presumptively eligible child, in writing, of the address and telephone number of the eligibility determination agency that the parent, guardian, caretaker relative or sponsoring adult chose.

(c) For any child for whom the approved presumptive eligibility determination entity is unable to determine presumptive eligibility, or who is ineligible under the criteria and standards of this subchapter or any other Division rules applicable to children, the approved presumptive eligibility determination entity shall refer the child to the appropriate eligibility determination agency for evaluation of potential eligibility for any other Medicaid or NJ KidCare programs. The address and telephone number of the appropriate eligibility determination agency shall be provided, in writing, to the parent, guardian, or caretaker relative of the child.

10:72-7.5 Presumptive eligibility process performed by the Division of Medical Assistance and Health Services

(a) Upon receipt of a properly completed certificate from the approved presumptive eligibility determination entity, Division staff shall:

1. Assign a presumptive eligibility number;
2. Create an eligibility record;
3. Issue a Medicaid eligibility identification card; and
4. Notify the approved presumptive eligibility determination agency and the appropriate county board of social services of the presumptive eligibility identification number assigned to the beneficiary.

10:72-7.6 Presumptive eligibility processing performed by the eligibility determination agency

(a) Upon receipt of the certificate of presumptive eligibility and a referral, if completed, from the approved presumptive eligibility determination entity, the eligibility determination agency shall check the Medicaid, Medically Needy, and NJ KidCare Eligibility database for existing Medicaid or NJ KidCare eligibility. If the child is receiving Medicaid benefits, Medically Needy benefits, or NJ KidCare benefits, no further action shall be required by eligibility determination agency.

(b) If the child is not currently receiving Medicaid or NJ KidCare benefits, the eligibility determination entities shall, notwithstanding the application disposition standards in N.J.A.C. 10:72-2.1(d), arrive at a case disposition within the presumptive eligibility period.

1. If the time period specified in N.J.A.C. 10:72-7.2(b)2 is exceeded, the eligibility determination agency shall notify the Division of Medical Assistance and Health Services of any such delay. The Division shall continue the child's presumptive eligibility until a final determination is made.
2. The eligibility determination agency shall also provide the applicant written notification of the specific reason(s) for the delay, prior to the expiration of the presumptive eligibility period in accordance with N.J.A.C. 10:72-7.8(b).

(c) In the case of a presumptively eligible beneficiary who is determined ineligible for New Jersey Care ... Special Medicaid Programs within the presumptive eligibility period, the child's eligibility shall terminate on the date of the eligibility determination. If the child is determined ineligible for any other Medicaid program, Medically Needy, or NJ KidCare, the eligibility determination agency shall provide a written notice of such denial and the reasons why, as set forth in N.J.A.C. 10:72-7.8.

10:72-7.7 Responsibility of the applicant

The parent, guardian, or caretaker relative of a presumptively eligible child shall contact the eligibility determination agency during the presumptive eligibility period by mailing an application to either the Statewide eligibility determination agency or arranging for a face-to-face interview with the county board of social services to complete the application process. As part of the eligibility determination process for Medicaid, the parent, guardian, or caretaker relative of a presumptively eligible child shall assist the eligibility determination agency in securing evidence that verifies eligibility.

10:72-7.8 Notification and fair hearing rights

(a) For a presumptively eligible child who is subsequently determined ineligible for Medicaid or NJ KidCare benefits:

1. The eligibility determination agency shall not be required to provide either timely or adequate notice for the end of the presumptive eligibility period. The presumptively eligible beneficiary shall not have any right to a fair hearing based on the termination of presumptive eligibility; and

2. The eligibility determination agency shall provide the child's parent, guardian or caretaker relative a notice of denial of the child's Medicaid application in accordance with N.J.A.C. 10:72-5.1. The presumptively eligible beneficiary shall have the right to apply for a fair hearing in accordance with N.J.A.C. 10:72-5.1 based on the denial of the application.

(b) For a presumptively eligible child whose eligibility for Medicaid or NJ KidCare has not yet been determined within the presumptive eligibility period, in accordance with N.J.A.C. 10:72-2.1(d)3, the eligibility determination agency shall provide the parent, guardian, or caretaker relative of the presumptively eligible child with written notification prior to the expiration of the presumptive eligibility period, setting forth the specific reasons for the delay in the application processing. The presumptively eligible beneficiary shall be entitled to a fair hearing based on the eligibility determination agency's failure to determine the child's Medicaid eligibility or ineligibility within the application processing period.

(c) A child denied presumptive eligibility by an approved presumptive eligibility determination entity shall not be entitled to adequate notice of that determination and shall not be entitled to a fair hearing on that action. The denial of presumptive eligibility shall not affect the parent's, guardian's or caretaker relative's right to apply for Medicaid or NJ KidCare on behalf of the child and to receive a formal determination of eligibility or ineligibility.

10:72-7.9 Scope of services during the presumptive eligibility period

All presumptively eligible New Jersey Care ... Special Medicaid Programs children under the age of one year shall be eligible during the presumptive eligibility period to receive on a fee-for-service basis all the Medicaid services defined at N.J.A.C. 10:49-

5.2.

10:72-7.10 Limitation on number of presumptive eligibility periods

All beneficiaries of presumptive eligibility for children who make an application for presumptive eligibility benefits for any Medicaid or NJ KidCare program shall be limited to one continuous presumptive eligibility period during the year, which shall be counted from the first day the applicant initially received presumptive eligibility.

END OF SUBCHAPTER 7

SUBCHAPTER 8. BREAST & CERVICAL CANCER PREVENTION AND TREATMENT ACT

10:72-8.1 Purpose and scope

The purpose of this subchapter is to provide the coverage stipulated in P.L. 2001, c.186, effective July 27, 2001, for women who are New Jersey residents who are under the age of 65 and who have been screened for breast and cervical cancer in accordance with the Breast and Cervical Cancer Prevention and Treatment Act, 42 U.S.C. § 1396a(aa), and who would not otherwise be eligible for the Medicaid program.

10:72-8.2 Definitions

The words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Creditable coverage" means, with respect to an individual, in accordance with Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996, coverage of that individual under any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act;
4. Title XIX of the Social Security Act, other than benefits solely under section 1928 of the Act;
5. Title 10, Chapter 55 of the United States Code;
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A State health benefits risk pool;
8. A health plan offered under Title 5, chapter 89 of the United States Code;
9. A public health plan;
10. A health benefit plan under 22 U.S.C. § 2504(e); or
11. Coverage of excepted benefits as defined in 29 U.S.C. § 1186(c).

10:72-8.3 Breast and cervical cancer-related prevention and treatment program eligibility

(a) An eligible individual shall:

1. Be a citizen or eligible qualified alien as defined in N.J.A.C. 10:72-3.2;
2. Be under 65 years of age;
3. Have been screened for breast or cervical cancer under the Federal Centers for Disease Control (CDC) Breast and Cervical Cancer Early Detection program established under Title XV of the Public Health Service (PHS) Act, and found to need treatment for either breast or cervical cancer (including a precancerous condition);

4. Not have creditable coverage; and

5. Meet all other Medicaid non-financial eligibility requirements as defined in N.J.A.C. 10:49-2, unless otherwise specified in this subchapter.

10:72-8.4 Presumptive eligibility process

In accordance with Pub.L. 106-354 and 42 U.S.C. § 1396a(aa), an individual referred to the Division by a CDC funded screening center shall be determined to be presumptively eligible for medical assistance in accordance with N.J.A.C. 10:72-7.5.

10:72-8.5 Service restrictions

In the case of an individual qualified for services in accordance with this subchapter, the only medical assistance provided shall be payment for services provided during the period in which the individual requires treatment for breast or cervical cancer.

10:72-8.6 Redetermination of eligibility

(a) A redetermination of medical eligibility shall be made every six months, and shall be based upon the need for continuing treatment for breast or cervical cancer, as determined by the individual's treating physician. Continuing treatment shall not include routine monitoring services. The treating physician shall complete a form provided for the purpose of certifying the continuing need for treatment and shall send the form to the county board of social services in the beneficiary's county of residence.

(b) The individual beneficiary shall provide, or shall assist in providing, information as requested by the county board of social services in order to determine continuing medical eligibility. Medical eligibility will be evaluated every six months.

(c) The county board of social services will assess non-financial eligibility factors every 12 months.

END OF SUBCHAPTER 8

SUBCHAPTER 9 NJ WORKABILITY

10:72-9.1 Purpose, scope and applicability

(a) The purpose of this subchapter is to establish requirements to implement the NJ WorkAbility program in accordance with N.J.S.A. 30:4D-1 et seq., as amended by P.L. 2000, c.116, and in accordance with the Federal Ticket to Work and Work Incentives Improvement Act, Public Law 106-170 (113 Stat. 1860), and 42 U.S.C. § 1396a(a)(10)(A)(ii)(XV). The purpose of the NJ WorkAbility program is to provide an opportunity for disabled individuals who are employed to purchase Medicaid coverage when their earnings would otherwise disqualify them for Medicaid.

(b) The rules apply to employed permanently disabled individuals residing in New Jersey who are between the ages of 16 and 64 whose earned incomes are below 250 percent, and unearned incomes below 100 percent, of the Federal poverty level for an individual or a couple. These individuals may apply to purchase Medicaid coverage (Medicaid buy-in) from the State of New Jersey, and shall pay for such coverage based on the standards contained in this subchapter.

(c) Unless specifically excepted, all other requirements of this chapter shall apply to the NJ WorkAbility program.

10:72-9.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Applicant" means any person who has made application for purposes of becoming a "qualified applicant."

"Commissioner" means the Commissioner of the Department of Human Services.

"Department" means the Department of Human Services.

"Director" means the Director of the Division of Medical Assistance and Health Services.

"Division" means the Division of Medical Assistance and Health Services.

"Medicaid" means the New Jersey Medical Assistance and Health Services program.

"Medical assistance" means payments made on behalf of beneficiaries to providers for medical care and services.

"Net income" means both earned and unearned income after disregards are taken in accordance with this subchapter.

"Provider" means any person, public or private institution, agency or business concern approved by the Division in accordance with N.J.A.C. 10:49, lawfully providing medical care, services, goods and supplies which are specified in this subchapter and holding, where applicable, a current valid license to provide such services or to dispense such goods or supplies.

"Qualified applicant" means a person who is a resident of this State who meets the requirements contained in this subchapter.

10:72-9.3 Non-financial eligibility for NJ WorkAbility

(a) Permanently disabled employed individuals who are 16 years of age or over, but under 65 years of age, shall be eligible to participate in the NJ WorkAbility program.

(b) Either the Social Security Administration or the Division's Disability Review Team may make the determination of permanent disability.

(c) The test of disability shall be identical to the SSI/SSDI disability test, except that employment activity, earnings and substantial gainful activity shall not be considered in determining whether the individual meets the definition of disability.

10:72-9.4 Income eligibility for NJ WorkAbility

(a) The earned income of a qualified applicant, after disregards, shall not exceed 250 percent of the Federal poverty level for a family unit of one or two, as applicable.

(b) The unearned income of a qualified applicant, after disregards, shall not exceed 100 percent of the Federal poverty level for a family unit of one or two, as applicable.

(c) Countable income for NJ WorkAbility individuals shall be determined in accordance with the income rules found at N.J.A.C. 10:71-5. All rules at N.J.A.C. 10:71-5 shall apply, with the following exceptions:

1. The disregard of cost-of-living increases in Social Security benefits provided for in N.J.A.C. 10:71-5.3(a)7x and xi shall not apply.
2. The deeming of the income of an alien's sponsor as provided for at N.J.A.C. 10:71-5.7 shall not apply.
3. Wages paid by the U.S. Census Bureau for temporary employment related to Census 2000 activities shall not be counted as income.
4. Social Security Disability benefits and Railroad Disability benefits received by the individual on his or her own account shall not be counted as income.

5. Nonrecurring lump sum income received by the household unit of a disabled individual shall be counted as income in the month received and any portion retained shall be counted as a resource in subsequent months.

(d) A disabled individual shall have the value of in-kind support and maintenance counted as unearned income in the following circumstances:

1. A disabled adult, who would, in accordance with rules at N.J.A.C. 10:71-5.6(c)4, be determined to be "living in the household of another," shall be considered to have unearned income in the amount specified at N.J.A.C. 10:71-5.4(a)12, less $20.00. The amount of income so assigned shall not be rebuttable by the applicant or beneficiary.

2. Any disabled person other than those addressed in (d)1 above, to whom food, clothing, or shelter is given or paid for by someone other than a spouse, parent, or minor child residing in the same household, shall be presumed to receive in-kind support and maintenance. The presumed value of the support and maintenance shall be the values specified at N.J.A.C. 10:71- 5.4(a)12. The presumed value so assigned may be rebutted in accordance with the provisions of N.J.A.C. 10:71-5.4(a)12i.

(e) In accordance with N.J.A.C. 10:71-5.5, the income of the spouse of a disabled individual shall be deemed to the disabled individual if they are residing in the same household. Income of the parent(s) of a disabled child under the age of 18 residing in the same household shall be deemed available to the child in determining income eligibility for benefits under this chapter. No income shall be deemed to a disabled individual from a person who is a member of a household unit of an eligible pregnant woman or child under the provisions of this chapter or a person who is in the budget unit of an eligible AFDC- related Medically Needy case (including a case that is eligible pending spend- down).

1. If the countable income (before income deeming) of the disabled individual exceeds the Federal poverty level for one person, he or she shall be ineligible for benefits and income deeming shall not apply.

2. When income of a spouse is deemed to a disabled individual, the total countable income after deeming shall be compared to the Federal poverty level for two persons.

3. In determining income eligibility of a child, the child's income after deeming shall be compared to the Federal poverty level for one person.

4. When the income of a spouse shall be deemed to both a disabled individual and a blind or disabled child, the income shall be first deemed to the disabled spouse. If the income (after deeming) of the disabled spouse does not exceed the Federal poverty level, he or she shall be income-eligible and there shall be no income to be deemed to the blind or disabled child. If the Federal poverty level is exceeded, the disabled adult shall be income ineligible and the excess income shall be deemed to the blind or disabled child.

5. When parental income shall be deemed to more than one blind or disabled child, the deemable income shall be divided equally among such children.

10:72-9.5 Resource eligibility for NJ WorkAbility

(a) Qualified applicants for NJ WorkAbility shall meet resources eligibility standards as defined in N.J.A.C. 10:71-4 in order to be eligible for benefits under this chapter.

(b) In the determination of countable resources, N.J.A.C. 10:71-4.2 shall apply.

(c) Eligibility shall not exist in any month in which the countable resources of a NJ WorkAbility person exceeds the limits of $20,000 for an individual and $30,000 for a couple.

(d) The spouse-to-spouse and parent-to-child deeming of resources found at N.J.A.C. 10:71-4.6 shall apply to eligibility for NJ WorkAbility. In the deeming of resources from one parent to a child, the countable parental resources in excess of the Medicaid Only resource limit for an individual shall be deemed to the blind or disabled child. When the resources of two parents shall be deemed to a child, the countable parental resources in excess of the Medicaid Only resource limit for a couple shall be deemed to the child.

(e) In addition to those resources excluded under N.J.A.C. 10:71-4.4, funds in an IRA, 401K or other retirement accounts shall also be excluded.

(f) The provisions at N.J.A.C. 10:71-4.6(f) requiring the deeming of resources of an alien's sponsor shall not apply.

10:72-9.6 Premium payments

(a) An eligible individual with net income in excess of 150 percent of the Federal poverty level shall pay a premium of $25.00 per month to the Division.

(b) An eligible couple with net income in excess of 150 percent of the Federal poverty level shall pay a premium of $50.00 per month to the Division.

(c) Premium payments required shall be submitted each month to:

Division of Medical Assistance and Health Services
NJ WorkAbility--Premiums
PO Box 712, Mail Code #27
Trenton, New Jersey 08625-0712

(d) Participants shall be billed in advance of the coverage month. Failure to submit the full contribution shall result in termination of coverage for the month following the coverage month where the premium has not been

received by the NJ WorkAbility program.

10:72-9.7 Services available through the NJ WorkAbility program

Services available through the NJ WorkAbility program shall be provided by the Division through its existing contracts with health maintenance organizations and fee-for-service providers.

10:72-9.8 Application process

(a) Applications shall be obtained from, and returned to, the county board of social services in the applicant's county of residence.

(b) Information can be obtained from the Division of Disability Services by calling toll free 1-888-285-3036 or at the address below.

Division on Disability Services
DHS-Capital Place I
PO Box 700, 1st Floor
Trenton, NJ 08625-0700